Remarks at a Town Hall Meeting and a Question-and-Answer Session on Health Care Reform

July 28, 2009

The President. Thank you. Thank you so much. I am just going to provide some brief remarks, and then I want to hear from you.

It is wonderful to be here today. I want to thank Mike for moderating this discussion. I want to thank Jennie and Barry for their extraordinary leadership here at AARP.

Some of you may know that 44 years ago today, when I was almost 4 years old, after years of effort, Congress finally passed Medicare, our promise as a nation that none of our senior citizens would ever again go without basic health care. It was a singular achievement, one that has helped seniors live longer, healthier, and more productive lives; it's enhanced their financial security, and it's given us all the peace of mind to know that there will be health care available for us when we're in our golden years.

Today, we've got so many dedicated doctors and nurses and other providers across America providing excellent care, and we want to make sure our seniors, and all our people, can access that care.

But we all know that right now we've got a problem that threatens Medicare and our entire health care system, and that is the spiraling costs of health care in America today. As costs balloon so does Medicare's budget. And unless we act, within a decade—within a decade—the Medicare trust fund will be in the red.

Now, I want to be clear: I don't want to do anything that will stop you from getting the care you need, and I won't. But you know and I know that right now we spend a lot of money in our health care system that doesn't do a thing to improve people's health. And that has to stop. We've got to get a better bang for our health care dollar.

And that's why I want to start by taking a new approach that emphasizes prevention and wellness, so that instead of just spending billions of dollars on costly treatments when people get sick, we're spending some of those dollars on the care they need to stay well, things like mammograms and cancer screenings and immunizations, commonsense measures that will save us billions of dollars in future medical costs.

We're also working to computerize medical records, because right now too many folks wind up taking the same test over and over and over again because their providers can't access previous results. Or they have to relay their entire medical history—every medication they've taken, every surgery they've gotten—every time they see a new provider. Electronic medical records will help to put an end to all that.

We also want to start rewarding doctors for quality, not just the quantity, of care that they provide. Instead of rewarding them for how many procedures they perform or how many tests they order, we'll bundle payments so providers aren't paid for every treatment they offer with a chronic—to a patient with a chronic condition like diabetes, but instead are paid for how are they managing that disease overall. And we'll create incentives for physicians to team up and treat a patient better together, because we know that produces better outcomes.

And we certainly won't cut corners to try to cut costs, because we know that doesn't work. And that's something that we hear from doctors all across the country. For example, we know that when we discharge people from the hospital a day early without any kind of coordinated followup care, too often they wind up right back in the hospital a few weeks later. If we had just provided the right care in the first place, we'd save a whole lot of money and a lot of human suffering as well.

Now, inally, we'll eliminate billions in unwarranted subsidies to insurance companies in the Medicare Advantage program, giveaways that boost insurance company profits but don't make you any healthier.

And we'll work to close that doughnut hole in Medicare Part D that's costing so many folks so much money. Drug companies, as a consequence of our reform efforts, have already agreed to provide deeply discounted drugs, which will mean thousands of dollars in savings for the millions of seniors paying full price when they can least afford it.

All of this is what health insurance reform is all about: protecting your choice of doctor; keeping your premiums fair; holding down your health care and your prescription drug costs; improving the care that you receive. And that's what health care reform will mean to folks on Medicare.

And we've made a lot of progress over the last few months. We're now closer to health care reform than we ever have been before. And that's due in no small part to the outstanding team that you have here at AARP, because you've been doing what you do best, which is organize and mobilize, and inform and educate people all across the country about the choices that are out there, pushing Members of Congress to put aside politics and partisanship, and finding solutions to our health care challenges.

I know it's not easy. I know there are folks who will oppose any kind of reform because they profit from the way the system is right now. They'll run all sorts of ads that will make people scared. This is nothing that we haven't heard before. Back when President Kennedy and then President Johnson were trying to pass Medicare, opponents claimed it was "socialized medicine." They said it was too much government involvement in health care, that it would cost too much, that it would undermine health care as we know it.

But the American people and Members of Congress understood better. They ultimately did the right thing. And more than four decades later, Medicare is still giving our senior citizens the care and security they need and deserve.

With the AARP standing on the side of the American people, I'm confident that we can do the right thing once again and pass health insurance reform and ensure that Medicare stays strong for generations to come.

So I'm hoping that I can answer any questions that you have here today. I'm absolutely positive that we can make the health care system work better for you, work better for your children, work better for your parents, work better for your families, work better for your businesses, work better for America. That's our job.

So thank you very much.

AARP Prime Time Radio Host Mike Cuthbert. Much as it would be every broadcaster's dream to share the podium with the President of the United States, he has to get wired up for sound. So I'll start with a question that was e-mailed in before the program, which combines a couple of factors you spoke about, Mr. President.

Health Care Reform/Health Insurance Providers/Preexisting Medical Conditions

He says: "My brother is 56 and uninsurable. He could afford to buy insurance, but he can't get it because he has a preexisting condition, and in his State, there is not a high-risk pool. When the President's program starts, will insurance companies be required to cover people with preexisting conditions? Will he be able to get insurance in the first phase of the plan, even if he's willing to pay the full amount?"

The President. The answer is yes. And so let me talk just a little bit about the kind of insurance reform that we're proposing as part of the broader reform package.

Number one: If you've got a preexisting condition, insurance companies will still have to insure you. Now, this is something very personal for me. My mother, when she contracted cancer, the insurance companies started suggesting that, well, maybe this was a preexisting condition, maybe you could have diagnosed it before you actually purchased your insurance. Ultimately, they gave in, but she had to spend weeks fighting with insurance companies while she's in the hospital bed, writing letters back and forth just to get coverage for insurance that she had already paid premiums on. And that happens all across the country. We are going to put a stop to that. That's point number one.

Point number two: We're going to reform the insurance system so that they can't just drop you if you get too sick. They won't be able to drop you if you change jobs or lose your job, as long as you're willing to pay your premiums. They are—we're going to make sure that we eliminate sort of the lifetime cap that creates a situation—a lot of times people get sick, then they find out the fine print says that at a certain point they just stop paying, or they'll pay for your hospitalization but they don't pay for your doctor, or they pay for your doctor but not your hospitalization.

We want clear, easy to understand, straightforward insurance that people can purchase. So that's point number one.

Point number two is, in addition to those reforms, we want to make sure that we set up what's called a health insurance exchange so that anybody who wants insurance but can't get it on their job right now, they can go to this exchange; they can select a plan that works for them or their families—these are private-option plans, but we also want to have a public option that's in there—but whatever you select, you will get high-quality care for a reasonable cost, the same way Congress, Members of Congress, are able to select from a menu of plans that they have available. And if you're very—if the plan that you select is still too expensive for your income, then we would provide you a little bit of help so that you could actually afford the coverage.

So the idea behind reform is: Number one, we reform the insurance companies so they can't take advantage of you; number two, that we provide you a place to go to purchase insurance that is secure, that isn't full of fine print, that is actually going to deliver on what you pay for; number three, we want to make sure that you're getting a good bargain for your health care by reducing some of the unnecessary tests and costs that have raised rates.

Even if you have health insurance, your premiums have gone up three times faster than wages over the last 10 years. Your out-of-pocket costs have gone up about 62 percent, which means that for people who aren't on Medicare right now, people, let's say, 54 to—or 50 to 64, a lot of those folks are paying much higher premiums than they should be, hundreds or thousands of additional dollars that could be saved if we had a system that was more sensible than it is right now.

Health Care Reform/Medicare Benefits

Mr. Cuthbert. We go to Margaret in Greeley, Colorado, for our first tele-town call. Go ahead, Margaret. Margaret, are you there? Let me ask Margaret's question for her. She wants to keep her good coverage. Will it continue with the new plan?

The President. Here's a guarantee that I've made: If you have insurance that you like, then you will be able to keep that insurance. If you've got a doctor that you like, you will be able to keep your doctor. Nobody is trying to change what works in the system. We are trying to change what doesn't work in the system.

And this—let me also address, I think, a misperception that's been out there that somehow there is any discussion on Capitol Hill about reducing Medicare benefits. Nobody is talking about reducing Medicare benefits. Medicare benefits are there because people contributed into a system. It works. We don't want to change it. What we do want is to eliminate some of the waste that is being paid for out of the Medicare trust fund that could be used more effectively to cover more people and to strengthen the system.

So, for example, right now we're paying about $177 billion over 10 years to insurance companies to subsidize them for participating in Medicare Advantage. Now, insurance companies are already really profitable. So what we've said is, let's at least have some sort of competitive bidding process where these insurance companies who are participating, they're not being subsidized on the taxpayer dime; if they've got better services, if they have better services that they can provide to seniors rather than through the traditional Medicare program, they're free to participate, but we shouldn't be giving them billions of dollars worth of subsidies.

That's the kind of change that we want to see; that will strengthen Medicare. But nobody is talking about cutting Medicare benefits. And I just want to make that absolutely clear, because we've received some e-mails and some letters where people are concerned that that may happen.

Mr. Cuthbert. Our operators, by the way, are telling us that we have literally tons of questions from people worried about keeping the care they have. On the other hand, Ollie in Texas, you've got a concern on the other end.

Hi, Ollie.

Health Care Reform

Q. Hello.

Mr. Cuthbert. Go ahead.

Q. May I start now?

The President. Yes.

Q. Yes. Well, I am an AARP volunteer, an AARP member. I support AARP's position on health care reform, and I want to thank President Obama for making this a priority issue on his agenda also.

My question is, there are so many negative ads and so many negative articles about the tremendous cost for health care reform that is being proposed by different congressional committees.

The President. Right.

Q. What we don't hear is what the dollar amount would be if we do nothing. And I think this is very important because people are scared by the trillions of dollars, and I know that if we do nothing for the next 10 years, health care will still keep on rising. And I want to know if the President has any way of putting out some information as to what it would cost if we do nothing. Thank you.

The President. Well, look, I think this is a great question, Ollie, and so let me try to be as specific as I can about the costs of doing nothing.

I've already mentioned that health care costs are going up much faster than inflation. All right? So your wages, your income, if you're lucky, right now maybe they're going up 2 percent a year, maybe 3 percent a year. For a lot of people they're not going up at all because the economy is in tough shape. But your health care costs are still going up 6 percent a year, 7 percent a year. Some people are getting notices in their mail, their premium just went up 20 percent.

On that trajectory, health care costs will probably double again. Your premiums will probably double again over the next 10 years. They may even go up faster than that. The costs of Medicare are going to keep on rising a lot faster than tax revenues coming in, which means that the trust fund—you've got more money going out than is coming in, which makes that more unstable. And we know that if we do nothing, we will probably end up seeing more people uninsured.

We're already seeing 14,000 people lose their health insurance every day—14,000 people. So the costs of doing nothing are trillions of dollars in costs over the next couple of decades—trillions—not billions, but trillions of dollars in costs, without anybody getting any better care.

So what we've said is, if we can control health care inflation, the—how fast costs are going up, then not only can we stabilize the Medicare trust fund, not only can we help save families money on their premiums, but we can actually afford to provide coverage to the people who currently don't have health care.

Now, here's the problem, that in order for us to save money, in some cases, we've got to spend some money up front. Let me give you some very specific examples. Health care IT: Health care is the only area where you still have to fill out five different forms. I'll bet when you go into the bank you don't have to do that. You've got an ATM. If you use your credit card, they'll find you real quick, and the billing is real easy—[*laughter*]—right? But for some reason, you go into health care, you fill out pencil and paper; I guess they Xerox it; they give it to somebody else. Sometimes you see their files and it's all stuffed with papers, and nurses can't read the doctor's handwriting.

So for us to set up a system like they have at the Cleveland Clinic that I just visited in Ohio, where every medical record—your privacy is protected, but everything is digitalized; everything—the minute you take a test, it goes to all the doctors and all the specialists that you might end up dealing with. So you end up just having that one test instead of having to then go back to the doctor again and again and again and have a bunch of different tests. Well, that saves money, but you've got to get the computer equipment in the first place to do it. So in some cases, we've got to spend some money on the front end.

I also think that if we provide coverage for people who don't have health insurance right now, then they are going to be getting preventive care, they're going to be getting screenings, and so they don't end up in the emergency room with really expensive care that all of us are paying for, even though we don't know it.

The average family is spending about $900 a year in higher health care premiums because they are paying indirectly for uncompensated care. Essentially, the insurance companies charge you a little more, and hospitals and doctors, they're all charging you a little bit more because they're not getting reimbursed for people who don't have any care whatsoever.

So what we've done is we've said, look, over 10 years, the health care reform proposals, to cover everybody, would cost about a trillion dollars over 10 years. So that's about $100 billion a year. Keep in mind we spend $2 trillion every year on health care, so this is just a fraction of what we spend. But we're talking about a trillion dollars over 10 years; that's $100 billion a year.

About 60 percent of that can be paid for by taking money that's already in the system but isn't working to make you healthier; that can pay for about 60 percent of it. So really what we're talking about is another 30 to 40 billion dollars every year to cover everybody, and we're going to get most of that money back if we're providing more prevention, more wellness, doctors and hospitals are being reimbursed more intelligently. Over time that money will—that investment will more than pay for itself.

But Ollie is exactly right, you get these stories where, oh, there's a trillion dollars here, a trillion dollars there, after a while it starts being real money, even here in Washington. And so I understand people being scared that this is going to be way too costly. It's not that costly if we start making changes right now.

Last point I would make, just to give you a sense of why I know that we can get savings in the system without over the long term spending more money: We spend about $6,000 per person more than any other industrialized nation on Earth, 6,000 more than the people do in Denmark or France or Germany or—every one of these other countries spend about—at least 50 percent less than we do, and you know what? They're just as healthy.

And I just had a doctor in my—in the Oval Office today who told me it's not because they're healthier; it turns out, they actually are generally older, and they smoke at a higher rate. And so, in fact, their costs should be higher than ours. And yet they are spending $6,000 per person less than we are.

Now, that's money out of your pocket. If you're already retired, it's money that is out of your pocket because some of that money could have been going into your retirement fund instead of going to pay for your health care. If you're working right now, some of that money could be going into your paycheck instead of going into your health benefits right now. It's money that is being given away, and we need to save it. That's why health reform is so important.

Mr. Cuthbert. Let's go next to Illinois and talk with Caroline with her question. Caroline, you're on the tele-town hall.

Independent Medical Advisory Committee/Medicare/National Deficit/Health Care Reform

Q. Thank you. Hello, Mr. President, from Joliet.

The President. Hi, Caroline. Good to—tell everybody in Joliet I said hi. [*Laughter*]

Q. I will, thank you. I came from our AARP prayer group/chapter meeting this morning, and I asked for questions. There were two big fears that were—that came out of the discussion. One had to do with the fear of losing a preferred insurance plan, which I think you've addressed to some extent this morning.

The President. Right.

Q. The other has to do with the knowledge that there will be millions of dollars of cuts in Medicare over the years to accommodate baby boomers. So the question is, does this translate into dictation of what can and cannot be given to a senior as service? For example, will there be fewer hip and knee replacements? Even if I decide when I'm 80 that I want a hip replacement, am I going to be able to get that? Am I going to be able to see a cardiologist or—if I have a heart condition—or other specialist? Or is that going to all be primary care?

I'm calling it rationing of care; I'm coining it that.

The President. Yes. No, I think it's an excellent question, Caroline, and I appreciate it because I do think this is a concern that people have generally.

My interest is not in getting between you and your doctor, although keep in mind, right now insurance companies are often getting between you and your doctor. So it's not as if these choices aren't already being made; it's just they're being made by private insurance companies, without any real guidance as to whether the decisions that are being made are good decisions to make people healthier or not. So what we've said is, we just want to provide some guidelines to Medicare, and by extension the private sector, about what works and what doesn't.

Some of you may have heard we wanted to set up what we're calling a IMAC, an independent medical advisory committee, that would, on an annual basis, provide recommendations about what treatments work best and what gives you the best value for your health care dollar. And this is modeled on something called MedPAC, which, by the way, Jennie, who is sitting right next to me, is currently on, and gives terrific recommendations every year about how we could improve care as to reduce the number of tests, or to make sure that we're getting more generic drugs in the system if those work and are cheaper, all kinds of recommendations like that. Unfortunately, right now they're just sitting on a shelf.

So we don't want to ration by dictating to somebody, okay, you know what, we don't think that this senior should get a hip replacement. What we do want to be able to do is to provide information to that senior and to her doctor about this is the thing that is going to be most helpful to you in dealing with your condition.

So let's say that person is diabetic. It turns out that if hospitals and doctors are providing reimbursements for a nurse practitioner or a social worker to work with that diabetic to control their diets and their medications, then they may avoid having to get a foot amputation. That's a good outcome. And by the way, that will save money. That saves Medicare money. And if we can save money on Medicare, that means that it's going to be more stable and more solvent over the long term.

So the thing that I'm—if I were—look, I think I'm scheduled to get my AARP card in a couple years. Is that right? [*Laughter*]

AARP Chief Executive Officer A. Barry Rand. Anytime you want one. [*Laughter*] Gladly.

The President. I know I'm automatically getting—associate member, right?
Okay. [*Laughter*]

So if I was thinking about Medicare and making sure that I was secure, the thing that I would be most worried about right now is health care inflation keeps on going up and the trust fund in 10 years is suddenly in the red. And now Congress has to make some decisions: Are they going to put more money into Medicare, especially given the deficits and the debt that we

already have? Or are they at that point going to start making decisions about cutting benefits, but not based on any science or what's making people healthier, they're just going to start making it based on politics?

And what we're saying is, we can avoid that scenario by starting to make some good decisions now about how do we improve care, make the system more rational, make it work better. That will actually stabilize and save Medicare over the long term.

One last point, because I think Caroline also raised the issue of we're taking some money out of Medicare. The only things that we're talking about have nothing to do with benefits. It has to do with things like subsidizing insurance companies, or, for example, right now we reimburse hospitals for the amount of time that you're there without checking to see if they're doing a good job in the first place. So they have no penalty. If you go into the hospital, they're supposed to fix you. Suddenly, you have to go back 3 weeks later. That hospital gets paid all over again, even though they didn't get it right the first time.

Now, if you got your car fixed at a mechanic, and 3 weeks later you had to go back, and you had to pay again to get your car fixed all over again, you'd be pretty mad, wouldn't you?

And yet when it comes to health care, that happens all the time. That happens all the time. And the hospital gets reimbursed for the second time or the third time, even though they didn't get it right the first time.

And so what we're saying is, let's incentivize the hospitals; we'll pay you a little bonus if the person is not readmitted because you got it right the first time. That will save money over the long term. Those are the kinds of changes we're talking about.

Mr. Cuthbert. We have been very geographically inspecific in our conversation so far, so let's get geographically specific by going to Jeanine in our audience. She's from Fairmont, Nebraska, and has a very relevant question.

Jeanine, welcome to the tele-town hall.

Health Insurance Providers/Health Care Reform

Q. Hi, Mr. President.

The President. Hi, Jeanine.

Q. I'm concerned about affordability and preexisting conditions, and I'm glad to hear you say what you have. My family and I live in rural Nebraska, and my husband and I are both—are self-employed, and we're paying—and he was originally denied because of a preexisting condition, and he's in a CHIPS pool. We're paying eight or nine hundred dollars a month, and we have an $8,000 deductible.

The President. Yes, that's tough.

Q. Yes, and it's, you know—and we've done this for about a year and a half. And we're not alone. There are a lot of people that do this.

The President. Well, Jeanine, you are a prime candidate for the health care exchange that I just described, because essentially what you would be able to do is you could just go online, you would be able to see a list of participating insurers, which by the way, is very important, because in most States right now insurance companies are dominated by—or the insurance market is dominated by just one or two insurers, so you don't have a lot of choices. And this way, you would have a lot of choices. They would all have to compete on the basis of price, but

they'd be abiding by a certain set of rules, like you can't exclude somebody for a preexisting condition.

And so you could then select the plan that was best for you, do your own comparison shopping. And if you qualified, then we would provide you a little bit of help on your premiums to reduce your costs. So that's what essentially we could pay for if we take some of these inefficiencies and the waste out of the system right now. That will pay for you getting the kind of help you need, and we'd have insurance regulations in place that would protect you from being scammed in the insurance market, which, unfortunately, a lot of people suffer from.

The other reason that we can drive your costs down is you'd be part of a huge pool, right? Part of the reason why large companies are typically able to offer lower insurance premiums for their employees than small companies is they've got a big pool. The Federal Government is a classic example. The Federal Health Employees Program is a pretty good deal because you've got several million people who are part of it. So that gives you a lot of bargaining power with the insurers. Well, the exchange will provide that same market power to help negotiate with the insurers to drive prices down.

And the other thing that we do want to do—now, this is controversial, and I understand some people are worried about this—we do think that it makes sense to have a public option alongside the private option. So you could still choose a private insurer, but we'd also have a public plan that you could choose from that would be non-for-profit, wouldn't have, hopefully, some of the same high administrative costs, and would be potentially more responsive to your needs at a lower cost. I think that helps keep the insurance companies honest because now they have somebody to compete with.

And I have to say, the reason this has been controversial is a lot of people have heard this phrase "socialized medicine," and they say, "We don't want Government-run health care; we don't want a Canadian-style plan." Nobody is talking about that. We're saying, let's give you a choice. You can choose the private marketplace or this other approach.

And I got a letter the other day from a woman; she said, "I don't want Government-run health care, I don't want socialized medicine, and don't touch my Medicare." [*Laughter*] And I wanted to say, well, I mean, that's what Medicare is, is it's a Government-run health care plan—[*laughter*]—that people are very happy with. But I think that we've been so accustomed to hearing those phrases that sometimes we can't sort out the myth from the reality.

Mr. Cuthbert. In our tele-town hall, we go next to Lawrence, Kansas, and talk with Mitzi. Mitzi, you're on the tele-town hall.

Health Insurance Providers/Health Care Reform

Q. Mr. President, thank you so much for doing the hard work of health care reform.

The President. Thank you, Mitzi.

Q. My question is, historically, older Americans, along with women of child-bearing age and persons with preexisting conditions, have paid more for health care coverage. And I want to know if reform will eliminate the disparity for older Americans.

The President. Well, the one thing that we strongly believe in is you can't discriminate in the insurance market. And that's actually what's happening right now. You're not seeing it in Medicare if you're already in Medicare, but if you're in the private marketplace right now, essentially insurance companies are cherry-picking. They want young, healthy people because

they can collect premiums and don't have to pay out a lot. And then as people get older, then they start suddenly making it harder for those folks to get coverage. And if they do get coverage, it's wildly expensive.

And so part of the insurance reforms we want to institute is to make sure that there's what's called a community rating principle that keeps every insurer operating fairly so that they can't just select the healthy, young people. If they want to participate in, for example, this health care exchange, they've got to take everybody. And that will help, I think, reduce costs or level out costs for older Americans. And we also want to enshrine a principle in there that says no discrimination against women, because there is still oftentimes a gender bias in terms of some of the coverage that people receive.

Mr. Cuthbert. We go next to North Carolina for a question we had all week last week. I think every town hall had this one. It's from Colin. And, Colin, go ahead and ask this question. Go ahead, Colin.

Living Wills/Health Care Reform

Q. This is his wife, Mary.

The President. Hi, Mary.

Q. Hi.

The President. What happened to Colin? [*Laughter*]

Q. Well, I'm the one they talked to.

The President. I got you. That's how it is in my house too. [*Laughter*]

Q. I have heard lots of rumors going around about this new plan, and I hope that the people that are going to vote on this is going to read every single page there. I have been told there is a clause in there that everyone that's Medicare age will be visited and told to decide how they wish to die. This bothers me greatly, and I'd like for you to promise me that this is not in this bill.

The President. You know, the—I guarantee you, first of all, we just don't have enough Government workers to send to talk to everybody, to find out how they want to die. I think that the only thing that may have been proposed in some of the bills—and I actually think this is a good thing—is that it makes it easier for people to fill out a living will.

Now, Mary, you may be familiar with the principle behind a living will, but it basically is something that my grandmother—who, you may have heard, recently passed away—it gave her some control ahead of time, so that she could say, for example, if she had a terminal illness, did she want extraordinary measures even if, for example, her brain waves were no longer functioning, or did she want just to be left alone. That gives her some decisionmaking power over the process.

The problem is, right now most of us don't give direction to our family members, and so when we get really badly sick, sadly enough, nobody is there to make the decisions. And then the doctor, who doesn't know what you might have preferred, they're making decisions, in consultation with your kids or your grandkids, and nobody knows what you would have preferred.

So I think the idea there is to simply make sure that a living will process is easier for people. It doesn't require you to hire a lawyer or to take up a lot of time. But everything is

going to be up to you. And if you don't want to fill out a living will, you don't have to. But it's actually a useful tool, I think, for a lot of families to make sure that if, heaven forbid, you contract a terminal illness, that you are somebody who is able to control this process in a dignified way that is true to your faith and true to you—how you think that end-of-life process should proceed.

You don't want somebody else making those decisions for you. So I actually think it's a good idea to have a living will. I'd encourage everybody to get one. I have one; Michelle has one. And we hope we don't have to use it for a long time, but I think it's something that is sensible.

But, Mary, I just want to be clear: Nobody is going to be knocking on your door; nobody is going to be telling you you've got to fill one out. And certainly nobody is going to be forcing you to make a set of decisions on end-of-life care based on some bureaucratic law in Washington.

Mr. Cuthbert. Mr. President, she mentioned, not in her question, but in her preview, that she's talking about Section 1232, the infamous page 425, which is being read as mandatory end-of-life care advice and counseling for Medicare. As I read the bill, it's saying that Medicare will, for the first time, cover consultation about end-of-life care, and that they will not pay for such a consultation more than once every 5 years. This is being read as saying every 5 years you'll be told how you can die.

The President. Well, that would be kind of morbid. [*Laughter*] I think that the idea in that provision, which may be in the House bill—keep in mind that we're still having a whole series of negotiations, and if this is something that really bothers people, I suspect that Members of Congress might take a second look at it. But understand what the intent is: The intent here is to simply make sure that you've got more information, and that Medicare will pay for it.

So, for example, there are some people who—they get a terminal illness, and they decide at a certain point they want to get hospice care. But they might not know how to go about talking to a hospice, what does it mean, how does it work. And they don't want to—we don't want them to have to pay for that out of pocket. So if Medicare is saying you have the option of consulting with somebody about hospice care, and we will reimburse it, that's putting more power, more choice in the hands of the American people, and it strikes me that that's a sensible thing to do.

Mr. Cuthbert. We go to Denver, Colorado, next, and Sarah, another doughnut hole question. Go ahead, Sarah.

Pharmaceutical Industry/Cost of Prescription Drugs/Health Care Reform

Q. Hi, this is my first year in the doughnut hole, and it's quite a frightening thing to go through. I have Parkinson's so I will be going through it year after year, and it looks like I could last about 2 years, and then all of my savings will be gone to the doughnut hole. So what do you intend to replace the doughnut hole with?

The President. Well, we wanted to replace it with prescription drugs that won't force you to use up all your retirement. When the original Medicare Part D was put forward, first of all, it wasn't paid for, so it automatically was unstable financially. Then there was an agreement that you couldn't negotiate with the drug companies for the cheapest available price on drugs. The American people pay about 77 percent more for drugs than any other country—77 percent—almost twice as much as other countries do.

So what we've said is, as part of reform, let's negotiate with the pharmaceutical companies; we'll cover more people—that means potentially the pharmaceuticals will have more coverage—or more customers—but as part of the deal, they've got to start providing much better discounts on their drugs. They've already committed that if the health care reforms pass, they would provide $80 billion worth of discounts. That would be enough to cover about half of the doughnut hole.

So right off the bat, right now, without further negotiations, the drug companies have already committed that they would reduce—they would cut in half the costs that folks have to go through when they're in the doughnut hole right now. That's money directly in their pocket that could be in their retirement savings.

I think we can get potentially an even better deal than that, because we're overpaying 77 percent. But the problem is, if we don't get health care reform, the pharmaceutical industry is going to fight for every dime of profits that they're currently making, and filling that doughnut hole is going to be very expensive, because when the Medicare Part D was originally passed, nobody put in provisions to pay for it, and so putting even more money into it at a time when Medicare may go bankrupt—not "go bankrupt," but go into the red 10 years from now—that's a big problem. That's part of the reason why reform is so important.

And I think for AARP members especially, there are hundreds of thousands of people out there who would directly benefit from reduced prescription drug costs if we're able to pass this bill.

Mr. Cuthbert. As you know, you may have heard the cost of the program is a concern. Jane here in our audience has a question about that. From Alexandria, Virginia, Jane.

Independent Medical Advisory Committee/Health Care Reform

Q. Hello, Mr. President. My question is some concern we have about the possibility of a cost containment commission, if you could comment on that.

The President. The idea is not the cost—it's not a cost containment commission that's been proposed. It's been what I just described, an independent medical advisory committee modeled on the kind of committee that is called MedPAC right now. It's got people who are health care experts, nurses, doctors, hospital administrators. The idea is how do you get the most value for your health care dollar.

Now, the objective is to control costs. But it's not cost containment by just denying people care that they need. Instead, it's reducing costs by changing the incentives and the delivery system in health care so that people are not paying for care that they don't need. The more we can reduce those unnecessary costs in health care, the more money we have to provide people with the necessary costs, the things that really pay high dividends in terms of people becoming healthier.

And this is pretty straightforward. I mean, it's pretty logical. If you think about your own family budget, if you could figure out a way to reduce your heating bill by insulating your windows, then that money that you saved—you're still warm inside; you're just as comfortable as you were—it's just you're not wasting all that energy and sending it in the form of higher bills to the electric company or the gas company. And that's then money that you can use to save for your retirement or help your kid go to college.

Well, it's the same principle within the health care system. If we can do the equivalent of insulating some windows and making the house more efficient, you're still going to be warm;

you're just going to be able to save some money. In this case, you're still going to be healthy; you will just have saved some money, and that money then we can use to lower your prescription drug costs, for example.

Health Care Reform

Mr. Cuthbert. We have an Internet question next from Alpharetta, Georgia. Robert asks: "If the new health care reform bill is so great for all Americans, why are Members of Congress and other arms of Government excluded from having to participate?"

The President. Well, I actually think that the health care exchange that people like Jeanine would be able to participate in would be very similar to the kind of program that we have for the Federal health care employees.

But keep in mind, I mean, this is something that I can't emphasize enough: You don't have to participate. You don't—if you are happy with the health care that you've got, then keep it. If you like your doctor, keep it. Nobody is going to go out there and say, "You've got to change your health care plan."

So this is not like Canada, where suddenly we are dismantling the system and everybody's signed up under some Government program. All we're doing is we're saying, if you've already got health care, the only thing we're going to do for you is we're going to reform the insurance companies so that they can't cheat you, and we are—if you don't have health insurance, we're going to make it a little bit easier for you to be able to obtain health care. And hopefully, overall, we are going to change the delivery systems so that we are saving money as a society over the long term.

So nobody is being forced to go into this system, and frankly the—if we do this right, then all we're actually doing is giving the American people the same option that Members of Congress have, because they've got a pretty good deal right now. I mean, the fact of the matter is, is that they don't have to worry about losing their health insurance. They have a bunch of options and different plans to select from. So if they've got a good deal, why shouldn't you? All right.

Mr. Cuthbert. We hope that you've found this tele-town hall with President Obama, AARP CEO A. Barry Rand, and AARP President Jennie Chin Hansen to be informative, interesting, helpful, and stimulating of further discussion. If you have a personal story you'd like to share with us about the impact the high cost of health care has had on your family, please stay on the line to leave us a message. Be sure to leave your contact information so we can get back to you.

Now for some closing remarks, let's get back to Barry Rand. Barry.

Mr. Rand. Well, I want to thank you again, Mr. President, for joining us, listening to our members, whether they're here in person or on the phone or on the web, and for hearing their stories, and getting a chance to talk directly and answer their questions. So we thank you very much for that.

The President. Thank you. Well, I just want to say thank you to all of you for taking the time to get informed on this issue. And I want to thank AARP for all the good that it has done to provide greater security and stability in the lives of people who are older.

You know, this week celebrates the anniversary of Medicare, and when you look at the Medicare debate, it is almost exactly the same as the debate we're having right now. Everybody

who was in favor of the status quo was trying to scare the American people saying somehow that Government is going to take over your health care; you won't be able to choose your own doctor; they're going to ration care; they're going to tell you, you can't get this or that or the other. And you know what? Medicare has been extraordinarily popular; it has worked; it has made people a lot healthier, given them security. And we can do the same this time.

Sometimes I get a little frustrated because this is one of those situations where it's so obvious that the system we have isn't working well for too many people and that we could just be doing better. We're not going to have a perfect health care system; it's a complicated system. There are always going to be some problems out there. But we could be doing a lot better than we're doing right now. We shouldn't be paying 50 percent more, 75 percent more than other countries that are just as healthy as we are. We shouldn't have prescription drugs 77 percent higher in costs than ours. And we shouldn't have people who are working really hard every day without health care or with $8,000 deductibles, which means they basically don't have health insurance unless they get in an accident or they get really sick.

That just doesn't make sense. And the stories I get are heartbreaking, all across the country, from people who are just having a really tough time, and it's going to get tougher. So we've got to have the courage to be willing to change things. I know that sometimes people have lost confidence in the country's ability to bring about changes, but I think this is one of those times where we've really got to step up to the plate, and it will, ultimately, make Medicare stronger, as well as the whole health care system stronger.

So thank you very much, everybody.

Mr. Cuthbert. One of the most difficult parts of working on an effort like health care reform is to keep in touch and keep up to date. May we suggest a web site: healthactionnow.org, that's healthactionnow—all one word—dot org. It will tell you how to get in touch with your Congressman and the people who are debating this whole issue and tell you how to keep involved until the very end, which we hope is soon.

Mr. President, Mr. CEO, Madam President, and everybody here and at home on the tele-town hall, we thank you all for participating. Keep up the good work, and we'll talk with you again. I'm Mike Cuthbert in Washington. Have a good day.

NOTE: The President spoke at 1:40 p.m. at AARP headquarters.

Categories: Addresses and Remarks : Health care reform :: Washington, DC.

Locations: Washington, DC.

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Subjects: AARP; Budget, Federal : Deficit ; Budget, Federal : National debt; Diseases : Cancer, research, prevention, and treatment; Diseases : Diabetes; Health and medical care : Cost control reforms; Health and medical care : Employer-based health insurance coverage; Health and medical care : End-of-life care; Health and medical care : Generic prescription drugs, approval process, improvement efforts; Health and medical care : Health insurance exchange, proposed; Health and medical care : Health insurance subsidy; Health and medical care : Hospitals :: Medicare and Medicaid reimbursement; Health and medical care : Hospitals :: Reimbursement for treatment of uninsured patients; Health and medical care : Independent medical advisory committee, proposed; Health and medical care : Information technology; Health and medical care : Insurance coverage and access to providers; Health and medical care : Living wills; Health and medical care : Medicare Advantage Plans, elimination of

overpayments; Health and medical care : Medicare and Medicaid; Health and medical care : Medicare Payment Advisory Commission (MedPAC); Health and medical care : Physicians :: Medicare and Medicaid reimbursement; Health and medical care : Prescription drugs, purchasing efficiency; Health and medical care : Preventive care and public health programs; Health and medical care : Seniors, prescription drug benefits.

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